TESTIMONY OF KATHLEEN DUNCAN
CERTIFIED NURSING ASSISTANT, ACTIVITIES DIRECTOR,
SOCIAL SERVICES DESIGNEE, ADMISSION DIRECTOR

Senator Grassley, members of the Special Committee on Aging:

I would like to thank you for inviting me to testify. This allows me the opportunity to be heard. I felt when I was working in Skilled Nursing Facilities (SNFs) as if few heard my complaints and even fewer cared. I hope that what I have to share with you gives you a better understanding of the daily occurrences in SNFs that led to me quitting the field. I could not make a difference, as one small voice. It is my greatest wish that this hearing may lead to changes that really make a difference in the quality of life and care given to California seniors in SNFs.

I quit working in SNFs but continued to work with seniors in California. My next employment in the senior field was at a municipal level and I found the work very rewarding. I have kept busy in many volunteer organizations. I was the District Coordinator for the AARP's Tax Aide program for the 1997 tax year. I am the Area Agency on Aging advisory board representative for Vacaville. I also sit on the board of directors for the Vacaville Social Service Corporation as a representative on senior issues. I am the mother of four children and was the caretaker/Durable Power of Attorney for my father. He passed away in a local nursing home in March of last year at 78 years old.

I have much I would like to share with you.

I began working with seniors in Pennsylvania as a home health care aide. I helped two to three seniors a day with their basic activities of daily living. I spent approximately 2 hours with each client. I enjoyed the work.

When I moved to California, my home state, I wanted to continue this work. I was not certified to work in California, my home state, I wanted to continue this work. I was not certified to work in California so I responded to an ad that stated I could become certified and be paid. I began my classes and was allowed to work almost immediately on the floor. My first assignment was to work the morning shift on Sunday in the Alzheimer wing of the SNF. I arrived and received my assigned residents. I was astonished to see 11 residents on my list, 8 with showers due that shift. It was the policy of that SNF to give the residents breakfast in their beds on Sunday. This sounds rather nice, but 6 of my assigned residents needed to be fed. Proper feeding techniques include insuring that the residents are eating the texture of meal that he or she can swallow. (i.e.; mechanical soft, slight pureed, pureed or almost a liquid state. Also liquids are difficult for some to swallow and may require thickening to prevent aspirating fluids into the lungs) It also means noting that the resident has completely swallowed what was fed before offering another bit. My training in Pennsylvania included feeding of clients with swallowing problems. I had not yet received training yet in classes in California. I was expected to feed residents that shift. Residents with swallowing problems need special care when being fed to insure that they swallow completely or they can aspirate food into their lungs. This special care takes extra time, time that morning that I did not know where I was going to find. I brought the food to the residents by room. Feeding everyone in the room, self-feeders and the feeders. This is how it should be done. How would you feel to be unable to feed yourself? Then you must sit looking at your food or watching your roommate eat? The correct way to pass food means that I had to go back to the kitchen and have trays warmed as I went to each room. In addition, CNAs must chart the percentage of food and liquid consumed. It is important to note changes in eating patterns. It is important to accurately administer and record fluids to prevent dehydration.

I now was faced with the daunting task of showering 8 residents. Alzheimer residents, in my experience, are more difficult to shower. I asked another CNA how was I expected to get this all done - his response "you'll get it." I spent most of the shift showering my residents. I answered call lights and nursing requests for assistance in between giving showers. As I worked, I noticed that either I had all the residents that needed showers or the other CNAs were just not doing them. There was only one large shower room on that wing.

There are other duties for me to accomplish in my shift. The residents in wheelchairs needed to be repositioned in their chairs to prevent decubitus ulcers/skin breakdown. I saw many residents with various stages of bedsores on them. I was taught in my classes that bedsores were preventable by: Cushioning boney prominences, Changing incontinent residents to keep them dry, Keeping residents hydrated and Repositioning them a minimum of every 2 hours. Most of the residents were in restraints. Restraints can prevent falling but also do not allow for self-repositioning in some cases. If a CNA was not aware a resident needed to go to the bathroom when restrained, it could cause the resident to wet him or herself. I feel this causes a loss of dignity and can become a habit with the resident, thus leading to the resident becoming incontinent. It is important for a CNA to take special care in repositioning residents or the delicate skin can bruise. The residents I cared for were incontinent and had to be kept dry to prevent decubitus ulcers/skin breakdown. I would also like to say that it is a matter of dignity to be kept clean and dry. The residents I cared for in my experiences often either denied they were wet or soiled or did not realize it because of cognitive impairments. I would have to check; asking was not always effective. It is also an important part of charting at the end of the shift. If a CNA notices that the resident is not urinating, it could mean they have an infection or a more serious condition. Bowel movements need to be accurately charted to note any possible bowel obstructions or constipation BEFORE it becomes a problem. I have heard many CNAs state "Hey, I asked and they said they were fine." I worked through my breaks and lunch that day and many of the days that followed.

The end of shift is the time to chart the care that was given. I HONESTLY charted what care I had given. I did notice that others near me charted that they showered their assigned residents and changed them. I knew that this was untrue. I reported this to my instructor, her response "Maybe you were mistaken or it may have been an unusual day." I worked other shifts and other wings of that hospital and it appeared to me that this lack of quality was the norm NOT the unusual.

I now understood what the CNA meant when he said I would "get it." He meant you do not necessarily do the care JUST chart that you do. I reported this to the hospital administrator. She said that she would investigate. I told her that when I searched for assistance I found many of the CNAs on the patio smoking and visiting. I also saw them in the break room during times when there were not breaks. At this time, I would also like to say that I feel the charting/evaluations done by the CNA is key to quality care. The CNA has the most personal contact with the resident. Proper care and assessment of the residents can be critical to preventing problems like skin breakdowns, dehydration, falls, and other conditions. The charting forms use/d by the CNAs are often a mere check list, where one CNA will copy whatever check mark was left by the previous CNA. I reported this charting failure by other CNAs. One week later, as these matters continued, I asked for a transfer to another building.

I began work at another building but many of the same problems seemed to be there also. I completed my certification training and passed the board. I began a new position the day I graduated - I started as an Activity Assistant. I enjoyed this position. I felt I was able to add much to the meaning and quality of life of the residents through recreation. I enrolled at American River College for the certification program for Activity Coordinator/Director. As an Activity Director, I was part of the care plan team. I was responsible for assessing the activity needs of each resident and record this assessment in the Minimum Data Set (MDS) in the section for Activities. I developed activities to meet these needs. I also

charted progress notes. I worked with the care plan team - with Nursing, Social Services and sometimes therapy. In my section of the MDS, I was to assess the amount of time spent in activities and in self-recreation. It was important to note anyone who might be an isolation case. This would require more in-room visits and other social charting by Social Services and in soem cases the nursing staff. There were times when I was asked STRONGLY to change my assessment because it was counter or not consistent with the others. I felt that by my criteria on the MDS I was correct in my assessments. Isolation is a problem that reflects into all aspects of the resident's life. They can mentally disassociate from others/withdraw. An alert and oriented resident is aware of their environment. An alert resident can demand care and report shortcomings. If they stay in their room, the care they receive is completely reliant on the call light system.

The call light system, in many of the hospitals I worked in, was insufficient at best. The call light must be in reach of the resident. The call light has to be answered in a timely manner. The resident must be cognitively alert enough to recognize the need to use the call light. A resident that is up and participating in activities has stimulants to all of their senses and a staff person with them in the room to help recognize their needs. It is more trouble for CNAs to get the resident up, properly cleaned and dressed than to wash them up a little and leave them in their bed. The nurse may have to move a resident to their room for treatments if they are in activities so it is easier for them if they leave the resident in their room. HOWEVER, they did not wish to TRIGGER the MDS as a possible isolation case because this would result in more charting and other triggers in the MDS. On more than one occasion, the Director of Nursing would change my section of the MDS to better match her assessment. In other words, she would promise to have her nurses take special care or order evaluations done for the resident if I would "go along with this." I felt that it was in my best interest to agree and sometime I got the care I thought the resident needed. I left that building taking a position as a social service designee.

THE SURVEY MADNESS

Documentation showing consistency is just one aspect of survey. There were many others. Survey is the main motivation of each building where I worked. I have been pulled from my to "help" another building where a survey was expected or they were in survey. Extra staff was always budgeted for those periods just before and during survey. I realize survey is supposed to be a "surprise" but it rarely is. The survey teams follow predictable patterns that the administrators of the various buildings were aware of. When the survey team arrived they witnessed more staff than was usual and a staff scared into providing the best care they could - care that should be the SAME quality all year round but was not.

I saw in two buildings medical record evaluation teams who would come before survey. They had personnel from other buildings and the nursing staff of the building that was expecting survey. This team would look over as many medical records as they could to find any problems. They would change the documents if needed. I witnessed nurses and others recreating medical records, sitting around a table with different pens back-dating records to "correct" them.

They survey teams arrival affected every area of the hospital. The housekeeping staff would be increased and any projects would be completed before the survey. Building projects -- from new tiles for residents' bathrooms to new lobby furniture -- would be completed. In one building I was in, just before survey, the lobby was redecorated by borrowing decorations from other buildings. These were returned after the survey. Making the facility a more homelike environment was a priority just before survey. Residents' rooms were decorated. New blankets and homey touches were added. All year I asked for money to decorate residents' rooms or the activity room, dining room, etc. and I would be told no but during survey, money was suddenly available. The monthly budget per resident for activities was less than $2. It was difficult to maintain equipment/supplies on this budget BUT if activities needed supplies during or before survey I was much more likely to get them, usually not out of the activity budget.

Company was coming, clean the house.

Survey is vital to the quality of care received by residents but residents deserve quality care all year not just around and during survey time. I suggest that smaller teams arrive to survey buildings in the area simultaneously and at unpredictable times. Take a "secret shopper" type of pre-survey. The afternoon, weekend, and night shifts would be a good time to arrive. Try walking around when there are little or no managers in the building. Managers tried to correct problems but often they had to SEE them first. Covering up was a way of life in the buildings where I worked.

My administrator asked me to assess the records on the personal care giving to residents: showers, dental hygiene, personal belongings. I found that personal property w as missing or not documented. Residents' belongings were in other residents' rooms. Some residents had no clothing on their intake sheets. In some cases, this was an accurate reflection of the residents' belongings and at other times it was not. As a social service designee, I contacted families to clothe these residents or looked into their resident fund to see if I could buy some clothes for them. I also contacted the Ombudsmen on this and other occasions, never receiving a reply. I asked the CNAs where the personal hygiene objects of the resident were. Many had no idea. I asked "So how did you brush his teeth this morning then?" They charted that they had provided dental.

In checking the ADL charts (Activities of Daily Living), I found that CNAs had charted that they had fed and showered residents that had passed away days prior. I reported these findings to the administrator and the medical records department did an audit finding many more problems. I do not believe that this was ever reported to licensing but I know the ADL's were corrected. I hope this illustrates to you how charting can say anything you want it to and that many CNAs do not pay close enough attention to their charting to realize that they charted for two days, all three shifts, on a person who was dead.

SHOW ME THE MONEY

I was offered a position away from the floor as an Admission Director. I took the position because I needed a mental break from the floor of the facility. The break did not last long. Maintaining census in the facility with quality admissions was more than a full-time job. It was impressed upon me the importance of keeping census up. Staffing was maintained by census and many in the building wanted to work. The corporation wanted admissions that had good, established medical insurance. I was instructed to focus my attention on admitting residents with Medicare or other insurance that could be billed for the ancillary services. I worked within the corporation guidelines but I expressed concerns about the ability to meet the needs of these admits that had a higher acuity level.

I worked closely with the DON (Director of Nurses) but eventually there was a shift in administrators and a new DON was hired. The new administrator decided that they would change my position to require a RN (Registered Nurse). I was offered to be kept on staff at the same level but as an Activity Assistant. For awhile I accepted this until the Activity Director was instructed to cut someone else and schedule me in the time. I did not want to be the reason for someone being fired and resigned. I left the Skilled Nursing Facility area and have not returned.

There are many other incidents I could share with you. I hope that this overview of my career in SNFs has provided you with enough information for you to formulate questions. Thank you for your time. I also offer my personal assistance in any way that I can to help in your endeavor.